fek

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

09911

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

**1. PLACE OF DEATH:**

County Wicomico

City or town Fruitland md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: no

Stay in hospital or inst. (yrs., or mos., or days) no

Stay in this community (yrs., or mos., or days) Life

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State md County Wicomico

City or town Fruitland md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. no
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR no

**3. (a) FULL NAME** Annie E Anderson

**3. (b) Social Security Number** no

4. Sex: female

5. Color or race: a.a.

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Henry K Anderson

6 (c) If alive, give age: Don't know years

7. Birth date of deceased (mo., day, yr.): about 1869

**8. AGE:** Years: about 71 | Months: — | Days: — | If less than one day: hrs. min.

9. Birthplace: Fruitland md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: no

FATHER
12. Name: George Pallett
13. Birthplace: Fruitland md

MOTHER
14. Maiden name: Margarett Black
15. Birthplace: Fruitland md

16. Informant: Henry K Anderson
Address: Fruitland, md

17. Burial
(Burial, cremation, or removal. Which?) Date thereof: Sept 29 (month) (day) (year)

Cemetery or crematory: Mt Calvery

Location: Fruitland, Md

18. Funeral director: James H Stewart

Address: Salisbury, Md.

19. 9/29 1940 Harriet E. Johnson
(Date rec'd by registrar) Local Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 24 1940, at 8 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1939, to Sept 24 1940, and that I last saw her alive on Sept 24 1940.

| Immediate cause of death | DURATION |
|---|---|
| Cardiac Thrombosis | 1940 |
| Due to Diabetes Insipidus | 1939 |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W O Darsey M D
M. D. or other

Address: Salisbury Date signed 9/27/40

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (72-B)

09912

## CERTIFICATE OF DEATH

Reg. Dist. No. 330

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

**1. PLACE OF DEATH:**
County Wicomico
City or town Mardella Springs md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: no
Stay in hospital or inst. (yrs., or mos., or days) no
Stay in this community (yrs., or mos., or days) 30 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Mardela Springs Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR No

**3. (a) FULL NAME** Clarence L Anderson

**3. (b) Social Security Number** No

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | a. a. | married |

6 (b) Name of husband or wife Luly L. Anderson
6(c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Aug 18 1865

8. AGE: Years 75 | Months — | Days 16 | If less than one day ____ hrs. ____ min.

9. Birthplace Pawnee Hill (Town, county, and state)

10. Usual occupation Minister

11. Industry or business no

FATHER
12. Name Samuel Anderson
13. Birthplace Pawnee Hill

MOTHER
14. Maiden name Sophia Riddin
15. Birthplace Pawnee Hill

16. Informant Mrs Luly L Anderson
Address Mardella Springs Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 10 1940 (month) (day) (year)
Cemetery or crematory Johns Wesley
Location Mardela Springs Md

18. Funeral director James F. Stewart
Address 402 E. Church St. Salisbury Md

19. Sept 10 1940 W H Robertson
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Sept 4 1940, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 4 1940, to Sept 4 1940, and that I last saw him alive on Sept 4 1940

| Immediate cause of death | Organic Heart Disease of Mitral Type | DURATION Unknown |
|---|---|---|
| Due to | | |
| Due to | | |
| Other conditions | | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE G. D. Browne M.D.
M. D. or other
Address Salisbury Md Date signed 8/5/40

RECEIVED
OCT 7 1940
BUREAU V. S.

# STATE OF MARYLAND—CERTIFICATE OF DEATH

09913

(97)

**1. PLACE OF DEATH**

County Wicomico Registration Dist. No. 335

Village or City Sharptown No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

**2. FULL NAME** Edna O. Baker If U. S. Veteran, specify WAR

(a) Residence: No. St., Ward.

(Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Clovis Baker

6. DATE OF BIRTH (month, day, and year) March 8 1871

7. AGE Years 69 Months 6 Days 11 If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. House work

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) N.Y.

FATHER

13. NAME Sanford Bundy

14. BIRTHPLACE (city or town) (State or country) N.Y.

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country) "

17. INFORMANT Allen Baker (Address) Sharptown Md.

18. BURIAL, CREMATION, OR REMOVAL Place Firemans Date Sept 20, 1940

19. UNDERTAKER Graveno Bros (Address) Sharptown Md

20. FILED 9/20, 1940 Mary R. Banks Registrar.

## MEDICAL CERTIFICATE OF DEATH

**21. DATE OF DEATH** Sept (Month) 18 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Sept 14, 1940, to Sept 18, 1940

I last saw her alive on Sept 17, 1940; death is said to have occurred on the date stated above, at 3 A.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Arterio Sclerosis | |
| Glaucoma | |

Other Contributary Causes of Importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) H. S. Kuhlman M. D.

(Address) Sharptown Md

*If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.*

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

(M)

(T)

# UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

**Example I**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Arteriosclerosis* | *1915* |
| *Chronic interstitial nephritis* | *1921* |
| *Cerebral hemorrhage* | *July 5, 1927* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gallstones* | *May 1, 1923* |
| | |
| | |

**Example II**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Attack of epilepsy* | *1 week ago* |
| *Run over by street car* | *1 week ago* |
| *Peritonitis* | *3 days ago* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gastroenteritis* | *1 year* |
| | |
| | |

RECEIVED
OCT 7 1929
U. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (170-e)

09914

# CERTIFICATE OF DEATH

Reg. Dist. No. 333

**1. PLACE OF DEATH:**
County Wicomico
City or town Salisbury, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: The Peninsula General Hosp.
Stay in hospital or inst. (yrs., or mos., or days) 1
Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md County
City or town Balto Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 201 S. Robinson St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Bognanni, Anthony, John

3. (b) Social Security Number 220-09-3643

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Single
B (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 12 1920

8. AGE: Years 20 Months 7 Days 22 If less than one day hrs. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual occupation Student
11. Industry or business
FATHER 12. Name Michael Bognanni
13. Birthplace Italy
MOTHER 14. Maiden name Frances Mandello
15. Birthplace Balto Md
16. Informant Father Michael Bognanni
Address 201 S. Robinson St
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 7 - 1940 (month) (day) (year)
Cemetery or crematory Holy Redeemer
Location Belair Road
18. Funeral director Frank V. Pipetone
Address 2800 Blk E. Baltimore St
19. 9/3, 1940 Harriet E. Johnson Balto. Md. Social Registrar
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1940, at 4 10/9 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw alive on 19
Medical Examiner's certificate
Immediate cause of death Basal fracture of skull and concussion of brain
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations none
Of autopsy none

DURATION 8 hrs

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 9-2-40
Where did injury occur? Whaleyville (City or town) Worcester (County) Md. (State)
Injured at home, farm, industry, public place (where?) Public highway
Means of injury Car lost control & turned over Injured at work? No

23. SIGNATURE L. A. Rademaker MD
Deputy Medical Examiner M. D. or other
Address Salisbury Md Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

RECEIVED
SEP 9 1940
BUREAU V. S.

Dr. Mann

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09915

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Wicomico
City or town: Parsonsburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: R.D. #2
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 29 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Parsonsburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: RD #2
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** Alida May Briggs

**3. (b) Social Security Number:**

4. Sex: Female | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry L. Briggs

6(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): June 22, 1877

8. AGE: Years: 63 | Months: 2 | Days: 17 | If less than one day: hrs. min.

8. Birthplace: Bridgewater N.J. (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: at Home

FATHER 12. Name: Cyrenus Porter

13. Birthplace: new york state

MOTHER 14. Maiden name: Anna Shroop

15. Birthplace: new york state

16. Informant: Harry L. Briggs
Address: R.D. #2 Parsonsburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 11 1940 (month) (day) (year)
Cemetery or crematory: Hammond Cem.
Location: Salisbury Md.

18. Funeral director: Fallows & Walter R. Fallows
Address: Salisbury Md.

19. 9/11/40 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 9, 1940 at (2 P.M.)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1936, to Sept 9 1940
and that I last saw her alive on Sept 8 1940

| | DURATION |
|---|---|
| Immediate cause of death: Valvular Heart Disease | Unknown |
| Due to: Decubitus | 2 mos |
| Due to: Hypertension | Unknown |
| Other conditions: Insanity | 4 yrs |

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Specify injury: Injured at work?

23. SIGNATURE: Hunter R Mann M. D. or other
Address: Salisbury Md Date signed: 9/11/40

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-2)

# CERTIFICATE OF DEATH

09916

Reg. Dist. No. 331

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Wicomico
City or town Hebron
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or insf. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 8 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Hebron Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Maggie L. Chesser

**3. (b) Social Security Number** 215-03-0184

4. Sex: Female
5. Color or race: White
6. (a) If single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: E. Cleveland Chesser
6(c) If alive, give age: 62 years
7. Birth date of deceased (mo., day, yr.): May 14, 1879.
8. AGE: Years: 61 Months: 3 Days: 20 If less than one day: hrs. min.
9. Birthplace: Accomac County Va. (Town, county, and state)
10. Usual occupation: Shirt factory operator
11. Industry or business: Shirt factory
FATHER 12. Name: Alfred D. Goundy
13. Birthplace: Blotom Va
MOTHER 14. Maiden name: Susan J. Blotom
15. Birthplace: Blotom Va.
16. Informant: G.C. Chesser
Address: Hebron Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/5/40 (month) (day) (year)
Cemetery or crematory: Crater Cem.
Location: Hallwood, Va.
18. Funeral director: Mrs C.G. Merrick & Sons
Address: Hebron Md.
19. Sept 4 1940 (Date rec'd by registrar) Mrs J. M. Wallop Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 3, 1940, at A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 18 1939, to Aug 5, 1940, and that I last saw h-r alive on Aug 5, 1940

Immediate cause of death: Carcinoma of the lung + mediastinum. — DURATION: ?
Due to: Congestive Heart failure
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Dr. John H. Heaman M. D. or other
Address 221½ Camden Ave Salisbury Date signed 9-3-40

RECEIVED
OCT 5 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B)

09917

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Wicomico

City or town Salisbury Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Peninsula General Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State County

City or town Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Salisbury

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Coffin.

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | W. | |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Stillborn.

8. AGE: Years Months Days If less than one day hrs. min.

Stillborn

9. Birthplace Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Thomas Tilden Coffin.

13. Birthplace Berlin, Md.

MOTHER 14. Maiden name Dorothy Mae Dare

15. Birthplace Salisbury, Md.

16. Informant

Address

17. Cremation Date thereof

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory P. G. Hospital

Location Salisbury Md.

18. Funeral director Supt. P. G. Hospital

Address Acting Salisbury, Md.

19. 9/5 1940 Gabriel E. Johnson Local Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2- 1940, 3:35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19, to 19,

and that I last saw h alive on 19.

| Immediate cause of death | DURATION |
|---|---|
| Stillborn | |
| foetus (5 mos) | |
| Due to | |
| | |
| Due to | |
| | |
| Other conditions | |
| | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Elizabeth A. Insley M. D. or other

Address Salisbury Md Date signed 9-3-40

RECEIVED
OCT 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B)

# CERTIFICATE OF DEATH

09918

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 107 Houston Street

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 Houston Street

(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME:** Stillborn Covington

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | C | single |

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 24, 1940

| 8. AGE: Years | Months | Days | If less than one day: hrs. | min. |
|---|---|---|---|---|
| Stillborn | | | | |

9. Birthplace: Salisbury, Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: William Covington

13. Birthplace: Princess Anne, Md

MOTHER — 14. Maiden name: Mary Dale

15. Birthplace: Snow Hill, Md

16. Informant: Mary Covington, Mother

Address: 107 Houston St., Salisbury, Md

17. Burial — Date thereof: 9-25-40

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Private

Location: Salisbury, Md

18. Funeral director: William Covington (acting)

Address: Salisbury, Md

19. 9/26/40 Harriet E. Johnson Local Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 24 1940, at 11:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 24 1940, to September 24 1940

and that I last saw h... alive on ... 19...

| Immediate cause of death | DURATION |
|---|---|
| Edema | |
| Premature | |
| Due to | |
| | |
| Due to | |
| | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: Harriet E. Johnson Local Registrar

Address: Salisbury, Md. Date signed: 9/26/40

RECEIVED
OCT 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

09919

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Peninsula Gen. Hospital
Stay in hospital or inst. (yrs., or mos., or days) Stillborn
Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md. County Somerset
City or town Princess Anne Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Baby Girl Doane

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Col | |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28, 1940

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| Stillborn | | | hrs. min. |

9. Birthplace Salisbury Wicomico Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Herbert Doane
13. Birthplace Princess Anne, Md

MOTHER
14. Maiden name Gladys Haywood
15. Birthplace Princess Anne, Md

16. Informant Father - Herbert Doane
Address Princess Anne, Md

17. Burial Date thereof 9/29/40
(Burial, cremation, or removal: Which?) (month) (day) (year)
Cemetery or crematory Greenwood (Salem)
Location Near Princess Anne, Md.

18. Funeral director Herbert Doane
Acting
Address Princess Anne, Md.

19. 9/29 1940 Harriet E. Johnson Local Registrar
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 28, 1940, at 1:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/28 1940 to 9/28 1940, and that I last saw h[illegible] on 9/28 1940.

| Immediate cause of death | DURATION |
|---|---|
| Stillborn infant | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clem T. Fisher M.D.
M. D. or other
Address Salisbury Md Date signed 9/29/40

RECEIVED
OCT 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(119a)

09921

# CERTIFICATE OF DEATH

Reg. Dist. No. 333

**1. PLACE OF DEATH:**

County Wicomico

City or town Salisbury Md (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Peninsula General Hospital

Stay in hospital or inst. (yrs., or mos., or days) 3 days

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State Maryland County Worcester

City or town Pocomoke Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 501 Laurel St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Beatrice Mae Evans

3. (b) Social Security Number

4. Sex Female

5. Color or race Colored

6. (a) Single, married, widowed, or divorced Baby

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1940

8. AGE: Years | Months 2 | Days | If less than one day hrs. min.

9. Birthplace Pocomoke Maryland (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Joseph Laws

13. Birthplace Pocomoke, Md

MOTHER 14. Maiden name Eleanor Evans

15. Birthplace Pocomoke, Md

16. Informant Samuel Savage

Address Accomac, Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/2/40 (month) (day) (year)

Cemetery or crematory

Location Chincoteague, Va

18. Funeral director J. E. Thomas

Address Accomac Va Box 243

19. 9/1, 1940 Harriet E. Johnson Local Registrar (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1 1940, at 6A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-29 1940, to 9-1 1940, and that I last saw her alive on 9-1 1940.

Immediate cause of death Malnutrition

Due to Gastroenteritis. Duration: not stated. Q.W.G.R.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION 2 months

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. W. Kerr, M.D. M. D. or other

Address Salisbury, Md Date signed 9/1/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

09922

# CERTIFICATE OF DEATH

Reg. Dist. No. 333

**1. PLACE OF DEATH:**

County Wicomico

City or town Salisbury Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 303 Water St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) about 7 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Salisbury Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 303 Water St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR no

**3. (a) FULL NAME** Irene Everett

**3. (b) Social Security Number** none

4. Sex: Female

5. Color or race: a.a.

6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife no

no 6(c) If alive, give age no years

7. Birth date of deceased (mo., day, yr.) July 9 1895

**8. AGE:** Years 45 Months 2 Days 7 If less than one day ___ hrs. ___ min.

9. Birthplace Boykins, Southhampton Co., Va.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business ✓

FATHER
12. Name Paul Everett
13. Birthplace Boykins Southhampton Co., Va

MOTHER
14. Maiden name Priscilla Yellarday
15. Birthplace Thelma, North Carolina

18. Informant Mrs. Minnie Taylor

Address 303 Water St, Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 21, 1940 (month) (day) (year)

Cemetery or crematory Mt Zion

Location Margrett N.C.

18. Funeral director James F. Stewart

Address 402 E. Church St, Salisbury Md

19. 9/20 1940 Harriet E. Johnson Local Registrar
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1940, at 8 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 17, 1940, Sept. 17, 1940, and that I last saw her alive on Sept. 17, 1940.

Immediate cause of death: Acute Dilatation of Heart — DURATION: Sudden

Due to: Myocarditis — Unk.

Due to: Pleural Effusion — 3 wks

Other conditions: due to a Possible Previous Pneumonia
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE G H Semobly MD
M.D. or other

Address Salisbury Md Date signed 9/20/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09923

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

**1. PLACE OF DEATH:**
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, Institution, or street address where death occurred: Records of Parsonage Baptist Church
How long in hospital or institution? 10 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Cor. Naylor & E. Church
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3. (a) FULL NAME:** Nancy V. Fletcher

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 4-1858

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 0 | 8 | hrs. min. |

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: retired
11. Industry or business: Home work
FATHER 12. Name: Mathias Fletcher
13. Birthplace: Virginia
MOTHER 14. Maiden name: Mary Cana
15. Birthplace: Virginia
16. Informant: Records of Parsonage Baptist Church
Address: Cor. Naylor & E. Church St. Salisbury Md
17. Buried (Burial, cremation, or removal. Which?) Date thereof: Sept. 16-1940 (month) (day) (year)
Cemetery or crematory: Mount Brook Cem.
Location: Near Parsonage Md.
18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Md.
19. 9/16/1940 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Sept. 12-1940 at 8 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1934, to Sept 12 1940
and that I last saw her alive on Sept. 10 1940

| Immediate cause of death | DURATION |
|---|---|
| Volvular Heart Disease | Unknown |
| Chronic Nephritis | Unknown |
| Due to | |
| Due to | |
| Other conditions: Oedema caused by Chronic Cardiac (Include pregnancy within 3 months of death) | 3 mos |

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hubert R Mann M. D. or other
Address: Salisbury Md Date signed: Sept 13-40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (S)

09924

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Peninsula General Hospital

Stay in hospital or insf. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Md. County: Wic.

City or town: Salisbury Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: Rte 4 (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** Bro. Foetus Fooks

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.):

8. AGE: Years | Months: Stillborn | Days | If less than one day: hrs. min.

9. Birthplace: (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER 12. Name: Mr. Josiah Fooks

FATHER 13. Birthplace: Salisbury, Md

MOTHER 14. Maiden name: Mrs. Ida Fooks

MOTHER 15. Birthplace: Princess Anne, Md

16. Informant:

Address:

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: (month) (day) (year)

Cemetery or crematory: P. G. Hospital

Location: Salisbury, Md.

18. Funeral director: Supt. P. G. Hospital (Acting)

Address: Salisbury, Md.

19. 9/18 (Date rec'd by registrar) 19 40 Harriet E. Johnson Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: September 10 19 40, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19, and that I last saw h alive on 19.

Immediate cause of death: Stillborn

Due to: Prematurity (5 months fetus)

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Aitkins, M.D. M. D. or other

Address: Salisbury, Md. Date signed: 9-16-40

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63)

## CERTIFICATE OF DEATH

09325

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
The Peninsula General Hospital

How long in hospital or institution? 13 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

**3. (a) FULL NAME:** Annie G Hales

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6.(b) Name of husband or wife: Charles Hales

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): June 1 - 1884

8. AGE: Years: 56 Months: 3 Days: 21 If less than one day: ...hrs. ...min.

9. Birthplace: Princess Anne Somerset. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: Elmer Goswellin
13. Birthplace: Maryland

MOTHER
14. Maiden name: Amanda Mariner
15. Birthplace: Maryland

16. Informant: Mr. Charles Hales

Address: Snow Hill Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 24/40 (month) (day) (year)

Cemetery or crematory: M E Cemetery

Location: Snow Hill Md

18. Funeral director: Pearse & Dennis

Address: Snow Hill Md

19. 9/23, 1940 (Date rec'd by registrar) Harriet E. Johnson Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 22 1940, at 6:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 9 1940, to Sept 22 1940

and that I last saw her alive on Sept 22 1940

| Immediate cause of death | DURATION |
|---|---|
| Acute Toxic Thyroid | hrs. |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: Acute Toxic Thyroid

Date of op. 9/19/1940

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Salisbury Date signed: 9/22/1940

RECEIVED
OCT 7 1940
BUREAU V. B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(940)

09926

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

**1. PLACE OF DEATH:**
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital or institution: N. Division Ext
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 73 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: R.F.D. #1.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** George W. Hammond

**3. (b) Social Security Number:**

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widower
6. (b) Name of husband or wife: Ella M. Hammond
6(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): Oct. 10 - 1866
8. AGE: Years: 73 Months: 10 Days: 29 If less than one day: hrs. min.
9. Birthplace: R.F.D. Parsonsburg Md
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: On Farm

FATHER
12. Name: Minos Hammond
13. Birthplace: R.F.D. Parsonsburg Md.

MOTHER
14. Maiden name: Malalia Wyatt
15. Birthplace: R.F.D. Pittsville Md

16. Informant: E. Mack Hammond.
Address: R.F.D. #1. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 11-1940 (month) (day) (year)
Cemetery or crematory: Forest Glen Cem.
Location: Near Parsonsburg Md
18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Md.

19. 9/11/1940 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 9th 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from [illegible] 19__, to [illegible] 19__, and that I last saw h[illegible] alive on [illegible] 19__

Immediate cause of death: Coronary Thrombosis — DURATION: 1 day

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] Deputy Medical Examiner
M. D. or other
Address: Salisbury, Md. Date signed: 9/10/40

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

09927

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Wicomico
City or town: Mt. Herman, Md. Route 4
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): —

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Mt. Herman, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Route 4
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: na

**3. (a) FULL NAME:** Rufus Hammond, Jr.

**3. (b) Social Security Number:** na

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | colored | Infant |

6 (b) Name of husband or wife: no
no 6(c) If alive, give age: na years

7. Birth date of deceased (mo., day, yr.): Sept. 5, 1940

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| — | — | — | 12 hrs. ____ min. |

9. Birthplace: Mt. Herman, Wicomico, Maryland
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Rufus Hammond
13. Birthplace: Snow Hill, Maryland

MOTHER
14. Maiden name: Mildred Harshon
15. Birthplace: Salisbury, Maryland

16. Informant: Rufus Hammond
Address: Mt. Herman, Md. Route 4

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 8, 1940 (month) (day) (year)
Cemetery or crematory: Public
Location: Salisbury Md

18. Funeral director: James F. Stewart
Address: Salisbury Md

19. 9/7/1940 (Date rec'd by registrar) Haskins E. Johnson Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 6 1940, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 5 1940, to Sept. 6 1940, and that I last saw h alive on Sept. 5 1940.

| Immediate cause of death | DURATION |
|---|---|
| Premature birth | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. S. Browne M.D.
M. D. or other
Address: 115 Mellow St. Salisbury, Md. Date signed: Sept. 6, 1940

RECEIVED
OCT 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH Xw

2411 N. Charles St., Baltimore (119-a)

09928

# CERTIFICATE OF DEATH

Reg. Dist. No. 333

**1. PLACE OF DEATH:**

County Wicomico

City or town Salisbury, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Peninsula Hospital

Stay in hospital or inst. (yrs., or mos., or days) 12 days

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md. County Worcester

City or town Bishopville R. F. D. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Thomas Nelson Hammond.

3. (b) Social Security Number

4. Sex Male

5. Color or race W.

6.(a) Single, married, widowed, or divorced —

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26. 1940.

8. AGE: Years | Months 87 | Days 19 | If less than one day hrs. min.

9. Birthplace Bishopville, Md.
(Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER
12. Name Thomas W. Hammond
13. Birthplace Delaware

MOTHER
14. Maiden name Viola Quillen
15. Birthplace Md.

16. Informant T. W. Hammond.
Address Bishop. Md.

17. Burial Date thereof Sept. 17, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bishopville, Md.

Location Bishopville, Md.

18. Funeral director Mrs. M. Pasha Watson
Address Selbyville Delaware

19. 9/16, 1940 Harriet E. Johnson Local Registrar
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1940, at 4P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 4 1940, to Sept 15 1940, and that I last saw him alive on Sept 15 1940.

Immediate cause of death Infectious diarrhea

DURATION mos

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Salisbury Date signed Sept 16

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 7 1940
BUREAU V. S.

09929

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

**1. PLACE OF DEATH:**

County Wicomico

City or town Fruitland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 614 Union St. Salisbury Md.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Anna M. - Handy

**3. (b) Social Security Number**

4. Sex: Female

5. Color or race: Col

6. (a) Single, married, widowed, or divorced: married

8 (b) Name of husband or wife: Wm Handy

6(c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1912

**8. AGE:** Years 28 | Months 7 | Days 30 29 | If less than one day ___ hrs. ___ min.

9. Birthplace Millsboro Del.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Private home

FATHER
12. Name Unknown
13. Birthplace —

MOTHER
14. Maiden name Unknown
15. Birthplace —

16. Informant Wm Handy
Address 614 Union St.

17. Buried
(Burial, cremation, or removal. Which?) Date thereof 9/6/40 (month) (day) (year)

Cemetery or crematory Salisbury ~~[illegible]~~ Cem.

Location Salisbury, Md.

18. Funeral director Mrs. Cl. Messick & Son's
Address Kelbor Md.

19. 9/4, 1940 Harriet E. Johnson Local Registrar
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1940, at 9 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from medical 19 , to autopsy 19 , and that I last saw h alive on 19

Immediate cause of death: Compound Fractured Skull, Concussion of brain, Fracture of Rt femur — DURATION 20 min

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations None

Of autopsy None

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Accident Date of 9-1-40

Where did injury occur? Fruitland (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?) Public highway

Means of injury Car - bus collision Injured at work? No

23. SIGNATURE Lakademaker M.D. Deputy Med Exam
M. D. or other

Address Salisbury, Md Date signed 9/2/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-E)

09930

# CERTIFICATE OF DEATH

Reg. Dist. No. 333

**1. PLACE OF DEATH:**

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: J. S. Hospital

Stay in hospital or inst. (yrs., or mos., or days) 12 days

Stay in this community (yrs., or mos., or days) " "

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md County Wicomico

City or town Clara Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. near Clara Post Office
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME George W. Hayward

3. (b) Social Security Number

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Maggie Hayward

6(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Nov 15 1883

8. AGE: Years 56 Months 10 Days 3 If less than one day ___ hrs. ___ min.

9. Birthplace Clara, Md.
(Town, county, and state)

10. Usual occupation Oysterman

11. Industry or business Oyster Industry

FATHER
12. Name John Hayward
13. Birthplace St. Mary County, Md

MOTHER
14. Maiden name Martha Wainright
15. Birthplace St Marys County Md

16. Informant Mrs Maggie Hayward
Address Clara Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Sept 20 1940
(month) (day) (year)

Cemetery or crematory Bivalve M.P. Cem

Location Bivalve M.P. Church

18. Funeral director Mrs C. Messick & Sons
Address Bivalve Md

19. 9/19, 1940 Harriet E. Johnson
(Date rec'd by registrar) Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1940, at 11.05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 5 1940, to Sept 17 1940, and that I last saw him alive on Sept 5 1940.

Immediate cause of death Intestinal obstruction

Due to Carcinoma of Ileum

Carcinoma of intestine C.W.G.R.

Due to Duration: Unknown

Other conditions Operation, September 11th, 1940.
(Include pregnancy within 3 months of death)

Major findings:
Of operations Obstruction

Of autopsy

DURATION
hr
hr

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Cate of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury Injured at work?

23. SIGNATURE [signature]
M. D. or other

Address Salisbury Date signed 9/18/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(T)

RECEIVED
OCT 7 1940
BUREAU V. S.

Dr. Nock

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137-a)

09931

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

**1. PLACE OF DEATH:**
County: Wicomico
City or town: Salisbury ~~R.D.#~~
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 73 years
Hospital, institution, or street address where death occurred: P.G. Hospital
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. #1.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3. (a) FULL NAME:** Asher Lee Hearn

**3. (b) Social Security Number**

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Mrs. Allie Hearn
6.(c) If alive, give age: 65 years
7. Birth date of deceased (mo., day, yr.): Oct. 15 - 1866

**8. AGE:** Years: 73 Months: 11 Days: 14 If less than one day: ..... hrs. ..... min.

9. Birthplace: Near Salisbury Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Hiram Hearn
13. Birthplace: Parsonsburg Md.

MOTHER
14. Maiden name: Irene Hearn
15. Birthplace: Parsonsburg Md.

16. Informant: Mrs. Allie Hearn
Address: R.D. # Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 2-1940 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md.

18. Funeral director: Holloway & E. Walter R. Holloway
Address: Salisbury Md.

19. 10/2, 1940 (Date rec'd by registrar) Harriet E. Johnson Social Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 29th 1940, at (a.m. 11.40 p.m.)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 6 1940, to Sept 29 1940 and that I last saw him alive on Sept 29 1940

Immediate cause of death: Hypertrophied Prostate — DURATION: Unk

Due to

Due to

Other conditions: Chr. Myocarditis — Unk
(Include pregnancy within 3 months of death)

Major findings of operations: Hypertrophied Prostate
Date of op. Sept 17 1940

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: R. M. Nock M. D. or other
Address: Salisbury Md. Date signed: 10/2/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(94a)

09932

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Wicomico
County
City or town Salisbury (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Poplar street
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 35 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 204 Ohio Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William Edward Howard

3. (b) Social Security Number

4. Sex Male | 5. Color or race White | 6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mrs. May Kemp Howard

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Dec. 1. 1868

8. AGE: Years 71 | Months 9 | Days 5 | If less than one day ____ hrs. ____ min.

9. Birthplace Marion station Md (Town, county, and state)

10. Usual occupation Salesman

11. Industry or business Paper Co. 520 N. Franklin Balto Md.

FATHER 12. Name Samuel Howard

13. Birthplace Somerset Co. Md.

MOTHER 14. Maiden name Sallie Conner

15. Birthplace Marion station Md.

16. Informant Mrs. May Kemp Howard

Address 204. Ohio Ave. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 9-1940 (month) (day) (year)

Cemetery or crematory Parsons Cem. Salisbury Md

Location Holloway & Co. Walter R. Holloway

18. Funeral director Salisbury Maryland

Address

19. 9/9 (Date rec'd by registrar) 1940 H. Harris E. Johnson Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6-1940, at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ____ 19__, to ____ 19__, and that I last saw him alive on ____ 19__

Immediate cause of death Coronary Thrombosis — DURATION 5 Mins

Due to Arteriosclerosis — Unknown

Due to: ____

Other conditions ____

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE Ja Faskerdine Wood Deputy Medical Examiner

M. D. or other

Address Salisbury, Md Date signed 9-7-40

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (168)

09933

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Wicomico

City or town: Salisbury Md R.F.D. (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Peninsula General Hospital

Stay in hospital or inst. (yrs., or mos., or days): one day

Stay in this community (yrs., or mos., or days): about two months

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury R.F.D. Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: no (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: no

**3. (a) FULL NAME:** Fredrick Isreal

**3. (b) Social Security Number:** 261-05-2334 ~~244-36-2534~~

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | a.a. | Single |

6 (b) Name of husband or wife: none

6(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): Feb 6 1911

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 29 | 7 | 8 | hrs. min. |

9. Birthplace: Jacksonville Florida (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER 12. Name: Joseph Isreal

FATHER 13. Birthplace: Florida

MOTHER 14. Maiden name: Dont know

MOTHER 15. Birthplace: Dont know

16. Informant: Alberta Parker

Address: Jacksonville Florida

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-21-40 (month) (day) (year)

Cemetery or crematory: Salisbury

Location: Salisbury

18. Funeral director: James H. Stewart

Address: Salisbury Md

19. 9/21/1940 (Date rec'd by registrar) Hattie E. Johnson Local Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Sept 15 1940, at 11 a 18 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~died~~ 19 ~~never~~, to ~~alive~~ 19 ~~saw her~~ and that I last saw h ~~alive~~ on 19

Immediate cause of death: Compound fractured skull — DURATION: 1 day

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: None

Of autopsy: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Homicide Date of 9-15-40

Where did injury occur? Salisbury (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Blow on head Injured at work? No

23. SIGNATURE: Sat Callender M.D. Deputy Medical Examiner M. D. or other

Address: Salisbury Md Date signed 9-18-40

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OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

09934

# CERTIFICATE OF DEATH

Reg. Dist. No. 333

**1. PLACE OF DEATH:**

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: "The Homestead" Camden Ave.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 91 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. "The Homestead" Camden Ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ✓

**3. (a) FULL NAME:** Sarah Jane Jackson

**3. (b) Social Security Number:** ✓

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widow

8 (b) Name of husband or wife: William H. Jackson

6(c) If alive, give age: ✓ years

7. Birth date of deceased (mo., day, yr.): April 18, 1848.

**8. AGE:** Years: 91 Months: 5 Days: 0 If less than one day: hrs. min.

9. Birthplace: Rockawalkin, Wicomico, Md. (Town, county, and state)

10. Usual occupation: ✓

11. Industry or business: ✓

FATHER

12. Name: Josephus Humphreys

13. Birthplace: Wicomico Co., Md.

MOTHER

14. Maiden name: Sarah A. Johnson

15. Birthplace: Wicomico Co., Md.

16. Informant: Miss Alice Humphreys

Address: Newton St., Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/20/40 (month) (day) (year)

Cemetery or crematory: Parsons

Location: Salisbury, Md.

18. Funeral director: The Hill & Johnson Co.,

Address: Salisbury, Md.

19. 9/20, 1940 Harriet E. Johnson Local Registrar (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 18, 1940, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/15 1940, to 9/18 1940, and that I last saw her alive on 9/17 1940.

Immediate cause of death: Apoplexy — DURATION: 3 days

Due to: Arterio sclerosis

Due to: Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations: none

Of autopsy: —

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Chas. T. Fisher M.D. M. D. or other

Address: Salisbury Md. Date signed: 9/18/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 7 1940
BUREAU V. S.

(Dr Rademaker)

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (169)

## CERTIFICATE OF DEATH

09935

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred: (Penn. R.R. Tracks)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 431. E. Williams
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Clayton Kaiser

3. (b) Social Security Number: 220-10-9743

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 20-1900

8. AGE: Years 40 | Months 1 | Days 27 | If less than one day ..... hrs. ..... min.

9. Birthplace Fredericksburg Md.
(Town, county, and state)

10. Usual occupation Fireman at Laundry

11. Industry or business Sunshine Laundry

FATHER
12. Name William Kaiser
13. Birthplace Philadelphia Pa.

MOTHER
14. Maiden name Nettie Wilson
15. Birthplace Fredericksburg Md.

16. Informant Mrs. Catherine Campbell
Address 431. E. Williams st. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 18-1940 (month) (day) (year)
Cemetery or crematory Bethel Cemetery
Location Near Parsonsburg Md.

18. Funeral director Holloway & Co. Walter R. Holloway
Address Salisbury Md.

19. 9/18/40 (Date rec'd by registrar) Harriet E. Johnson Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1940 at about 7.02 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... to ..... 19.....
and that I last saw h... alive on ..... 19.....

| Immediate cause of death | DURATION |
|---|---|
| Crushed chest | instant death |
| Due to amputation of left leg | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operation None
Date of op.
Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 9-16-40
Where did injury occur? Salisbury (City or town) Wicomico (County) Md (State)
Injured at home, farm, industry, public place (where?) Railroad Tracks
Means of injury Train ran for deceased Injured at work? no

23. SIGNATURE J. LaRademaker M.D.
Deputy Medical Examiner
M. D. or other
Address Salisbury Md Date signed 9/17/40

RECEIVED
OCT 7 1940
BUREAU V. S.

09936

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (119-a)

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

**1. PLACE OF DEATH:** Wicomico

County

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? P.S. Hospt.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 217 E. Nine st.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Callahan F. Lankford

**3. (b) Social Security Number**

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Baby

6.(b) Name of husband or wife

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 26, 1940

8. AGE: Years | Months 3 | Days | If less than one day ..... hrs. ..... min.

9. Birthplace 217 E. Nine st. Salisbury Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Alton C. Lankford
13. Birthplace Seaford Del.

MOTHER
14. Maiden name Pauline Mellett
15. Birthplace Salisbury Md.

16. Informant Alton C. Lankford

Address 217 E. Nine st. Salisbury Md.

17. Burial. Date thereof Sept. 28-40
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parsons Cem.

Location Salisbury Md.

18. Funeral director Holloway & C. Walter R. Holloway

Address Salisbury Md.

19. 9/28/40 Harriet E. Johnson Local Registrar
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26-1940 (at 9.30 p.m.)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1940, to Sept 26 1940

and that I last saw him alive on Sept 25 1940

Immediate cause of death: Infectious diarrhea — DURATION: 3 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Wimmer M. D. or other

Address Salisbury Date signed Sept 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 7 1940
BUREAU V. S.

Dr. Kitts

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (41-a)

## CERTIFICATE OF DEATH

09937

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred: P.B. Hoyt
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Wicomico Co
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 214. Locust Terrace
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** Willard Wesley Lawrence

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Baby. |

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 15. 1940

8. AGE: Years | Months | Days: 2 | If less than one day: hrs. min.

9. Birthplace: P.B. Hoyt. Salisbury Md
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: John Wesley Lawrence
13. Birthplace: New York City N.Y.

MOTHER
14. Maiden name: Charlotte J. Davis
15. Birthplace: Wicomico Co Maryland

16. Informant: Mr. John W. Lawrence
Address: 214 Locust Terrace Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 18-1940 (month) (day) (year)
Cemetery or crematory: Parsons Cem
Location: Salisbury Md.

18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Md.

19. 9/18/40 (Date rec'd by registrar) Harriet E. Johnson Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 17 1940 at 10.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary atelectasis | 2 days |
| Due to | |
| Due to | |
| Other conditions: One of twins | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Nature of injury: Injured at work?

23. SIGNATURE: A.W. Kitts, M.D.
M. D. or other
Address: Salisbury, Md. Date signed:

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09938

## CERTIFICATE OF DEATH

Reg. Diat. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Wicomico

City or town Salisbury Maryland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Peninsula General Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md. County Worcester

City or town Stockton Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** GEORGE WESLEY MANUEL

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | COLORED | Single |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 16 1939

8. AGE: Years 1 | Months 14 3 | Days 17 | If less than one day hrs. min.

9. Birthplace Stockton, Md. (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Ray Purnell

13. Birthplace Md.

MOTHER 14. Maiden name Sable Manuel

15. Birthplace Md.

16. Informant Irvine Bennett

Address Stockton, Md.

17. Burial Date thereof 9/28/40 (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory Home Beneficial Cem.

Location Stockton, Md.

18. Funeral director Irvine Bennett

Address Stockton Md.

19. 9/28 1940 Harriet E. Johnson Local Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9-27 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-26 1940, to 9-27 1940, and that I last saw h alive on 9-27 1940.

| Immediate cause of death | DURATION |
|---|---|
| Congenital Lues. | 1 Yrs |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Irvine R. Manuel M. D. or other

Address Salisbury Md. 9/27/40 Date signed

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-C

09939

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Peninsula General Hospital

Stay in hospital or inst. (yrs., or mos., or days): 4 days

Stay in this community (yrs., or mos., or days): Life

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury Rt. 2 Ward No. 1
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: na
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: na

**3. (a) FULL NAME:** Nairne, Isaac

**3. (b) Social Security Number:** na

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | a a | Single |

6 (b) Name of husband or wife: na

6(c) If alive, give age: na years

7. Birth date of deceased (mo., day, yr.): about 1910

8. AGE: Years: 29 | Months: — | Days: — | If less than one day: hrs. min.

9. Birthplace: Salisbury md
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: na

FATHER
12. Name: Arthur Nairne
13. Birthplace: Salisbury md

MOTHER
14. Maiden name: Ida Johnson
15. Birthplace: Snowhill md

16. Informant: Arthur Nairne
Address: Salisbury md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/7/40 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Fruitland md

18. Funeral director: James H. Stewart

Address: Salisbury md

19. 9/7 (Date rec'd by registrar) 19 40 Harriet E. Johnson Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 4 1940, at 9 05 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from [illegible] 19--, and that I last saw him alive on [illegible] 19--.

Immediate cause of death: Basal Fracture of skull
Concussion of brain — DURATION: 2 days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None

Of autopsy: No

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 9-1-40

Where did injury occur? Eden (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?): Public highway

Means of injury: Car bus collision Injured at work? No

23. SIGNATURE: La Rademaker M.D. Deputy Medical Examiner
M. D. or other

Address: Salisbury, Md Date signed: 9/4/40

RECEIVED
OCT 7 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122a)

09940

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

**1. PLACE OF DEATH:**

County Wicomico

City or town Salisbury Md (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Peninsula General Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State Maryland County Somerset

City or town Princess Anne Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. Route (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Newman, William

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Rena Newman

Princess Anne, Md 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1862

8. AGE: Years 78 Months 2 Days 22 If less than one day hrs. min.

9. Birthplace Princess Anne, Md. (Town, county, and state)

10. Usual occupation Farming

11. Industry or business

FATHER 12. Name Sidney C. Newman

13. Birthplace Princess Anne Md.

MOTHER 14. Maiden name Virginia Price

15. Birthplace Princess Anne Md.

16. Informant Lavinia Newman

Address Princess Anne Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 21, 1940 (month) (day) (year)

Cemetery or crematory Monie Cemetery

Location Monie, Maryland

18. Funeral director Dale Dashiell

Address Princess Anne, Md.

19. 9/19, 1940 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1940, at 1:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 14 1940, to Sept 19 1940, and that I last saw h— alive on Sept 19 1940.

Immediate cause of death Cardiac Failure

Due to Chronic Myocarditis

Due to

Other conditions Strangulated Hernia (Include pregnancy within 3 months of death)

Major findings:

Of operations Strangulated Hernia & Gangrene

Of autopsy Mestion

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE R. M. Nash M. D. or other

Address Salisbury Date signed 9/19/40

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-21)

# CERTIFICATE OF DEATH

09941

Reg. Dist. No. XI 336

**1. PLACE OF DEATH:**

County Wicomico

City or town Delmar, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 50 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Delmar, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. R. F. D. 3
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Elizabeth Anna Nichols

**3. (b) Social Security Number**

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: George Nichols

6(c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) Feb 24, 1864

**8. AGE:** Years 76 | Months 6 | Days 14 | If less than one day ____ hrs. ____ min.

9. Birthplace Wicomico County, Md.
(Town, county, and state)

10. Usual occupation House work

11. Industry or business Home

FATHER
12. Name Geo. W. Killiam
13. Birthplace Maryland

MOTHER
14. Maiden name Hannah Lowe
15. Birthplace Maryland

16. Informant George Nichols

Address Delmar, Md.

17. Burial
(Burial, ~~cremation, or removal. Which?~~)

Date thereof 9/11/40
(month) (day) (year)

Cemetery or ~~cremetory~~ Nichols

Location Delmar, Md.

18. Funeral director Will S. Marvel

Address Delmar, Delaware

19. Sept. 11 1940 Harry B. Hadson
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9/8/ 1940, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1939, to Sept 8 1940, and that I last saw her alive on Sept. 5 1940.

Immediate cause of death: Myocarditis

DURATION: ?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE H. E. Lecates
M. D. or other

Address Delmar Del. Date signed 9/10/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 5 1960
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

09942

# CERTIFICATE OF DEATH

Reg. Dist. No. 333

**1. PLACE OF DEATH:**
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: RD #4. Salisbury
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 62 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. R.D. # 4
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Clarence Nickerson

**3. (b) Social Security Number**

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Single
B (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): No Record

**8. AGE:** Years 62 | Months | Days | If less than one day hrs. min.

9. Birthplace near Pittsville Md.
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business On Farm
FATHER
12. Name Henry Nickerson
13. Birthplace Pittsville Md.
MOTHER
14. Maiden name Emma Brown
15. Birthplace Pittsville Md.
16. Informant Handy Nickerson
Address Triett St. Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 12 1940 (month) (day) (year)
Cemetery or crematory Parsons Cem.
Location Salisbury Md.
18. Funeral director Holloway & Co. Walter R. Holloway
Address Salisbury Md
19. 9/12/1940 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1940, at 3 a.m. approx M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death: Medical examiner's certificate
Coronary Thrombosis

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations No
Of autopsy None

DURATION: Instant

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. LaRadie Baker M.D. Deputy Medical Examiner
M. D. or other
Address Salisbury Md Date signed 9/11/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (70)

09943

## CERTIFICATE OF DEATH

Reg. Diat. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 607 Delaware St,

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 1 yr

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 607 Delaware St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** Mildred Virginia Price

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Col. | — |

6 (b) Name of husband or wife: —

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 28, 1939.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| — | 11 | 12 | hrs. min. |

9. Birthplace: Salisbury, Wicomico, Md.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business:

FATHER
12. Name: Charles H. Price
13. Birthplace: Quantico, Md.

MOTHER
14. Maiden name: Mary Moore
15. Birthplace: Sharptown Md.

16. Informant: Charles Price
Address: 607 Delaware St, Salisbury

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/11/40 (month) (day) (year)

Cemetery or crematory: Sharptown Col. Cem.

Location: Sharptown Md.

18. Funeral director: Mrs. C. Messick Davis

Address: Hebron, Md.

19. 9/11 19 40 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 9, 1940, at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1940, to Sept 1940, and that I last saw h— alive on Sept 9 1940

| Immediate cause of death: Exhaustion | DURATION |
|---|---|
| Due to: Pronounced Fever | |
| Due to: | |
| Other conditions: Rickets | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: D. Allen Dield M. D. or other

Address: 9-14-40 Salisbury Md. Date signed

RECEIVED
OCT 7 1940
BUREAU V. S.

Dr. Lynch

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

## CERTIFICATE OF DEATH

09944

Reg. Dist. No. 333

**1. PLACE OF DEATH:**
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo. 15 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Wicomico County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. #3
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** Williamanna Traden Roberts

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6.(b) Name of husband or wife: Alonzo C. Roberts
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Nov. 14 - 1858

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 9 | 27 | hrs. min. |

9. Birthplace: R.D. #3 Salisbury Md
(Town, county, and state)
10. Usual occupation: at Home
11. Industry or business:

FATHER
12. Name: George W. Leonard
13. Birthplace: Near Salisbury Md.

MOTHER
14. Maiden name: Mary E. Williams
15. Birthplace: Near Salisbury Md.

16. Informant: Irving Leonard
Address: R.D. #3. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 13-1940 (month) (dey) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md
18. Funeral Director: Holloway & Co. Walter R. Holloway
Address: Salisbury Md.

19. 9/13/40 Harriet E. Johnson Registrar
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 11-1940 (5:30 P.M.)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 12 1940, to Sept 11 1940; and that I last saw h alive on Sept 11 1940.

| Immediate cause of death | DURATION |
|---|---|
| Uremic coma | 3 days |
| Due to: Chronic Nephritis | 3 yrs |
| Due to: | |
| Other conditions: Carcinoma of Stomach | 2 yrs |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. H. Lynch M. D. or other
Address: Salisbury Md. Date signed: 9/13/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
SEP 21 1940
BUREAU V. S.

(Dr. Fisher)

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

## CERTIFICATE OF DEATH

09945

Reg. Dist. No. 333

**1. PLACE OF DEATH:**
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred: P.S. 1 Hosp.
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 919 Railroad Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3. (a) FULL NAME:** Thomas Scanlon

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): No Record

| 8. AGE: Years | Months | Days | If less than one day: hrs. | min. |
|---|---|---|---|---|
| 75 | . | | | |

9. Birthplace: Mineral Ridge Ohio (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: retired
12. FATHER — Name: Henry Scanlon
13. FATHER — Birthplace: Dublin Ireland
14. MOTHER — Maiden name: Mary Higgins
15. MOTHER — Birthplace: Dublin Ireland
16. Informant: Wico. Count Welfare Board
Address: Salisbury Md.
17. Buried (Burial, cremation, or removal? Which?) Date thereof: Oct 1-1940 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md
18. Funeral director: Holloway & Collier R.
Address: Salisbury Md.
19. 10/1/40 (Date rec'd by registrar) Harriet E. Johnson Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Sept. 29, 1940 (3:20a) at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-25 1940, to 9/29 1940
and that I last saw him alive on 9/29 1940

| Immediate cause of death | DURATION |
|---|---|
| Lobar Pneumonia | 4 days |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Holloway & Collier Funeral Home
M. D. or other
Address: Salisbury Md. Date signed: 10/1/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
OCT 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(122-b)

09946

# CERTIFICATE OF DEATH

Reg. Dist. No. 333

**1. PLACE OF DEATH:**

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Pen. Gen. Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Md. County: Worcester

City or town: Stockton Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Harold Selby

**3. (b) Social Security Number:** 218-07-8951

4. Sex: Male

5. Color or race: Col.

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): —

**8. AGE:** Years: about 40 | Months: — | Days: — | If less than one day: ____ hrs. ____ min.

9. Birthplace: Delaware (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: General laborer

FATHER: 12. Name: Edward Selby

13. Birthplace: Delaware

MOTHER: 14. Maiden name: Cora Selby

15. Birthplace: Delaware ?

16. Informant: Irving Bennett

Address: Stockton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/15/40 (month) (day) (year)

Cemetery or crematory: Foreman Cem.

Location: Stockton, Md.

18. Funeral director: Irvine Bennett

Address: Stockton, Md.

19. 9/12 1940 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/12 1940, at 12 mo

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/12 1940, to 9/12 1948, and that I last saw him alive on 9/12 1948.

Immediate cause of death: Intestinal obstruction — DURATION: [illegible]

Due to: Unknown

Primary cause of the intestinal obstruction: Unknown. C.W.G.B.

Died before any operation was performed; autopsy was refused.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ✓

Of autopsy: ✓ Autopsy was refused.

**PHYSICIAN** Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ✓ Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ✓

Means of injury: injured at work?

23. SIGNATURE: R. M. Mich. M. D. or other

Address: Salisbury Date signed: 9/12/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

RECEIVED
OCT 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

09947

Reg. Dist. No. 333

**1. PLACE OF DEATH:**
County Wicomico
City or town Salisbury, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Pen. Genl. Hospital
Stay in hospital or inst. (yrs., or mos., or days) 1 day
Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State N. J. County
City or town Woodbury Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 14 Steward St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME Annabelle Smith
3. (b) Social Security Number

4. Sex Female
5. Color or race Col.
6. (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife Charles Smith
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 15, 1905

8. AGE: Years 35 | Months 4 | Days 26 | If less than one day hrs. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual occupation Laundress
11. Industry or business
FATHER 12. Name William Bantum
13. Birthplace Md.
MOTHER 14. Maiden name Eliza Carroll
15. Birthplace Md.
16. Informant Charles Smith
Address 14 Steward St. Woodbury, N.J.
17. Burial Date thereof 9/14/40
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md
18. Funeral director Joseph C. Locke, Jr.
Address 304 N. Central Ave. Balto. Md.
19. 9/12, 1940 Harriet E. Johnson Local Registrar
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9-11- 1940, at 8:20 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-11- 1940, to 9-11- 1940, and that I last saw her alive on 9-11- 1940.

Immediate cause of death Coronary Thrombosis — DURATION 1 day
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Swanner M.D.
M. D. or other
Address Salisbury Date signed Sept 12

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

09948

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Wicomico — WITHIN CITY LIMITS
City or town: Salisbury
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 300 Newton St.
Stay in hospital or inst. (yrs., or mos., or days): V
Stay in this community (yrs., or mos., or days): 11 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 300 Newton
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: V

**3. (a) FULL NAME:** William H. Smith

**3. (b) Social Security Number:** 211-14-3021

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife: Riley M. Smith
6(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Mar. 18, 1864.

8. AGE: Years: 75 | Months: 10 | Days: 10 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Bethel, Sussex, Delaware
(Town, county, and state)

10. Usual occupation: Construction Supt.

11. Industry or business: Ship building

FATHER
12. Name: Joseph Smith
13. Birthplace: Sussex Co., Delaware.

MOTHER
14. Maiden name: Deborah Holder
15. Birthplace: Sussex Co., Delaware.

16. Informant: Mrs. Riley M. Smith,
Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/1/40 (month) (day) (year)
Cemetery or crematory: Bethel Methodist
Location: Bethel, Delaware.

18. Funeral director: De Hill & Johnson Co.,
Address: Salisbury, Md.

19. 9/30/40 (Date rec'd by registrar) Harriet E. Johnson, Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 28, 1940, at 1:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 21, 1940, to Sept 28, 1940, and that I last saw him alive on Sept 27, 1940.

| Immediate cause of death | DURATION |
|---|---|
| Cerebral Hemorrhage | 1 mo 7 da |
| Due to Hypertension | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Howard R Mann, M. D. or other
Address: Salisbury Md — Date signed 9/29/40

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09949

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

**1. PLACE OF DEATH**

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 mo. 17 days

Hospital, institution, or street address where death occurred: 800 Monroe st

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. 800 Monroe
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Flossie Ann Staton

**3. (b) Social Security Number**

4. Sex: female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Baby.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 4-1939

**8. AGE:** Years | Months 10 | Days 17 | If less than one day ..... hrs. ..... min.

9. Birthplace 800 Monroe st. Salisbury Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Geo. Elmer Staton
13. Birthplace Princess Anne Md.

MOTHER
14. Maiden name Florence Banks
15. Birthplace Fruitland Md.

16. Informant Geo. Elmer Staton
Address 800. Monroe st. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 22-1940 (month) (day) (year)

Cemetery or crematory Parsons Cem.

Location Salisbury Md.

18. Funeral director Holloway & Co. Walter R. Holloway

Address Salisbury Maryland

19. 9/22 1940 Harriet E. Johnson Local Registrar
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21-1940 19 (at 7 P M)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 21 1940, to Sept 21 1940 and that I last saw him alive on Sept 21 1940

Immediate cause of death: Infectious diarrhea — DURATION: 10 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M.D.
M. D. or other

Address Salisbury Md Date signed Sept 22

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37-a)

09920

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: P. G. Hospital

Stay in hospital or inst. (yrs., or mos., or days): 5 days

Stay in this community (yrs., or mos., or days): life

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Hebron Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Ellis Stephen Thomas

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

8 (b) Name of husband or wife: Katharine Ellis

6(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): April 9, 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 5 | 6 | hrs. min. |

9. Birthplace: Delaware (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: James T. Ellis

13. Birthplace: Delaware

MOTHER — 14. Maiden name: Leah Ann Waller

15. Birthplace: Hebron Md.

16. Informant: Katharine Ellis

Address: Hebron Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/22/40 (month) (day) (year)

Cemetery or crematory: Parsons Cem.

Location: Salisbury Md.

18. Funeral director: Mrs. A. B. Messick & Sons

Address: Hebron Md.

19. 9/21, 1940 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Sept 20 1940, at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1940 to Sept 20 1940, and that I last saw him alive on Sept 20 1940.

| Immediate cause of death | DURATION |
|---|---|
| (a) Acute Myocarditis | 1 day |
| (b) Coronary Thrombosis | |
| Due to: Chr. Myocarditis | |
| Due to | |
| Other conditions: Prostatic Hypertrophy | Indefinite |

(Include pregnancy within 3 months of death)

Major findings:

Of operations: Prostatic Hypertrophy

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: Salisbury Date signed 9/20/40

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74-a)

09950

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Worcester

City or town Salisbury Sub. 1 Troy
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) —

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md. County Worcester

City or town Berlin Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

**3. (a) FULL NAME** Marrel L. Thomas

**3. (b) Social Security Number** —

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | W | M |

B (b) Name of husband or wife Catherine Thomas

6(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) July 13, 1870

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 2 | 8 | hrs. min. |

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation Railroad

11. Industry or business —

FATHER 12. Name Edwin Thomas

13. Birthplace Md.

MOTHER 14. Maiden name Eliza Lewis

15. Birthplace Md.

16. Informant Mrs. L. Thomas

Address Berlin Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 22 (month) (day) (year)

Cemetery or crematory Centerville Md.

Location Centerville

18. Funeral director J. W. Purnell

Address Berlin Md.

19. 9/21 1940 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1940, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 1940, to Sept 21 1940

and that I last saw h alive on Sept 21 1940

| Immediate cause of death | DURATION |
|---|---|
| Coronary Thrombosis | Hrs |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings: —

Of operations —

Of autopsy —

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE J. W. Purnell M. D. or other

Address Berlin Md. Date signed 9/21/1940

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

# CERTIFICATE OF DEATH

09951

Reg. Diat. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, Institution, or street address where death occurred:
John B. Parsons' Home
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:** Same.
(For newborn infants give residence of mother)
State Maryland County ~~Wicomico~~
City or town ~~Salisbury~~ Maryland (Crisfield)
(If outside city or town limits, write RURAL and give nearest town)
Street No. ~~John B. Parsons' Home~~
(If rural, give LOCATION)
2.(a) If veteran, name war

**3. (a) FULL NAME** Mrs. Effie L. Pilchman

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6.(b) Name of husband or wife Bates Pilchman
6.(c) If alive, give age ~~years~~

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1872

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 10 | 10 | hrs. min. |

9. Birthplace Crisfield (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Kingate Lewis
13. Birthplace Accomac Co. Virginia

MOTHER
14. Maiden name Catherine Pruitt
15. Birthplace Crisfield

16. Informant Miss Edith M. Moore
Address John B. Parsons' Home

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 12, 1940 (month) (day) (year)
Cemetery or crematory Crisfield Cem.
Location Crisfield
18. Funeral director The Hill & Johnson Co.
Address Salisbury, Md.

19. 9/11 1940 Harriet E. Johnson Registrar
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1940, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1940, to Sept 10 1940
and that I last saw h~~er~~ alive on Sept 10 1940

| Immediate cause of death | DURATION |
|---|---|
| Chr. Valv. Heart. | 1938 |
| Due to Chr. Int. Nephritis | 1939 |
| Due to Uremia | 1940 |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. D. Lacy M.D.
M. D. or other
Address Salisbury, Md. Date signed 9/10/40

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

09952

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Peninsula General Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1/3 day

Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Snow Hill Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION) No

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Ward, William Norman

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2 1923

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 17 | 5 | 24 | hrs. min. |

9. Birthplace Paulsboro New Jersey

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Norman S. Ward

13. Birthplace Maryland

MOTHER 14. Maiden name Mary Elizabeth Marshall

15. Birthplace Virginia

16. Informant Mr. Norman S. Ward

Address Snow Hill Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 29/40 (month) (day) (year)

Cemetery or crematory Trinity Lemain

Location Snow Hill

18. Funeral director Hearne & Dennis

Address Snow Hill Md

19. 9/28, 1940 Harriet E. Johnson

(Date rec'd by registrar) Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1940, at 7.58 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____, 19__, to ____, 19__, and that I last saw him alive on ____, 19__. I have/have not/ a medical examiner's certificate on file.

| Immediate cause of death | DURATION |
|---|---|
| Fractured 3rd cervical Vertebra | 6 hrs |
| Due to Laceration of spinal cord | 6 hrs. |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 9-25-40

Where did injury occur? Snow Hill (City or town) Worcester (County) Md (State)

Injured at home, farm, industry, public place (where?) public highway

Means of injury car overturned Injured at work? No

23. SIGNATURE LaRademaker MD Deputy Medical Examiner

M. D. or other

Address Salisbury Md Date signed 9/26/40

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OCT 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (13)

09953

# CERTIFICATE OF DEATH

Reg. Dist. No. 333

**1. PLACE OF DEATH:**
County Wicomico
City or town Salisbury (Rural)
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Eastern Shore NB Sanatorium
Stay in hospital or inst. (yrs., or mos., or days) 10 mo 29 d.
Stay in this community (yrs., or mos., or days) life

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Salisbury Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 713 Pearl St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Lewis Watson
3. (b) Social Security Number: none

4. Sex: male
5. Color or race: white
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Minnie Watson
6(c) If alive, give age 52 years
7. Birth date of deceased (mo., day, yr.): August 10, 1878
8. AGE: Years 62 | Months 1 | Days 12 | If less than one day ___ hrs. ___ min.
9. Birthplace: Dames Quarter, Somerset Co Maryland (Town, county, and state)
10. Usual occupation: handyman
11. Industry or business
FATHER
12. Name: Charles Watson
13. Birthplace: unknown
MOTHER
14. Maiden name: Julia Messick
15. Birthplace: Somerset Co, Md.
16. Informant: deceased (on admission)
Address
17. Burial Dames Quarter (Burial, cremation, or removal. Which?) Date thereof Sept 23 (month) (day) (year)
Cemetery or crematory: Dames Quarter Md
Location: Dames Quarter Md
18. Funeral director: [illegible]
Address: Dale Island Md
19. Sept. 23 1940 (Date rec'd by registrar) Harriet E. Johnson Social Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 22 1940, at 905 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/23/39 19 , to 9/22/40 19 , and that I last saw him alive on 9/21/40 19 .
Immediate cause of death: Pulmonary Tuberculosis — DURATION 6 yrs
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Paul Chen, MD
M. D. or other
Address: Salisbury Date signed 9/22/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 7 1940
BUREAU V. S.

09954

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-L)

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

**1. PLACE OF DEATH:**
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred: 404 Hazel ave
Now long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 404 Hazel ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Josephine Wheatley

**3.(b) Social Security Number**

4. Sex: female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Sept. 26-1923

**8. AGE:** Years 16 | Months 11 | Days 17 | If less than one day ... hrs. ... min.

9. Birthplace: Laurel Del.
(Town, county, and state)
10. Usual occupation: at Home
11. Industry or business

FATHER
12. Name: Luther Wheatley
13. Birthplace: Cambridge, Md.

MOTHER
14. Maiden name: Margaret Mitchell
15. Birthplace: Laurel Del.

16. Informant: (Mother) Mrs Margaret Smullen
Address: 404 Hazel ave. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 17 1940 (month) (day) (year)
Cemetery or crematory: Parsons Cem
Location: Salisbury Md

18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Md

19. 9/17 1940 Harriet E. Johnson Sodl
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 13th 1940 at (5 P.M.)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1940, to Sept 13 1940
and that I last saw her alive on Sept 13 1940

Immediate cause of death: myocarditis uraemia

Due to: Chronic nephritis

Due to: Propsy

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Gardiner Spring M.D. M. D. or other
Address: Salisbury Md Date signed: Sept 17/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

09955

# CERTIFICATE OF DEATH

Reg. Dist. No. 333

**1. PLACE OF DEATH:**

County: Wicomico

City or town: Salisbury, Rural No. 4
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 years

Hospital, institution, or street address where death occurred: ✓

How long in hospital or institution? ✓

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Salisbury, R.D. 4.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

**3. (a) FULL NAME:** Margaret Malone White

**3. (b) Social Security Number:** 220-01-8351

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Purnell S. White, Jr.

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Jan. 30, 1916.

**8. AGE:** Years: 24 Months: 7 Days: 16 If less than one day: ..... hrs. ..... min.

9. Birthplace: Near Salisbury, Wicomico, Md.
(Town, county, and state)

10. Usual occupation: Office Secretary

11. Industry or business:

FATHER
12. Name: Hartwell M. Malone
13. Birthplace: Wicomico Co., Md.

MOTHER
14. Maiden name: Agnes Pryor
15. Birthplace: Wicomico Co. Md.

16. Informant: Purnell S. White, Jr.
Address: Salisbury, Md. R.D. 4.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/18/40 (month) (day) (year)

Cemetery or crematory: Parsons

Location: Salisbury, Md.

18. Funeral director: The Hill & Johnson Co.,
Address: Salisbury, Md.

19. 9/18 1940 Harriet E. Johnson Local Registrar
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 16, 1940, at 6.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1938, to Sept 16 1940 and that I last saw her alive on Sept 16 1940

Immediate cause of death: Valvular Heart Disease — DURATION: 14 yrs

Due to: Focking Scarlet Fever

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Hunter R Mann M. D. or other

Address: Salisbury Md Date signed: 9/16/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46-E

# CERTIFICATE OF DEATH

Reg. Dist. No. 3553 09956

**1. PLACE OF DEATH:**

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: S. Division st. Ext

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 72 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md County Wicomico

City or town Salisbury Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. S Division st. Ext

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Oliver Stump White

**3. (b) Social Security Number**

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Widower

B (b) Name of husband or wife Betty J. White

6(c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) No Record

**8. AGE:** Years 72 | Months | Days | If less than one day hrs. min.

9. Birthplace Salisbury Md.

(Town, county, and state)

10. Usual occupation retired Salesman

11. Industry or business Furniture store

FATHER

12. Name E. H. White

13. Birthplace Wye Mills Md.

MOTHER

14. Maiden name Sarah Kimmey

15. Birthplace East New Market Md.

16. Informant Ralph K. White

Address 302 S. Div. st. Salisbury Md

17. Burial Date thereof Sept. 6 1940

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Shad Point Cem.

Location Shad Point Md.

18. Funeral director Holloway & Co. Walter R. Holloway

Address Salisbury Md.

19. 9/6 1940 Harriet E. Johnson Local Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4-1940 19 (1.30 P M) at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12 1940, to Sept 1, 1940, and that I last saw him alive on Sept 1, 1940.

Immediate cause of death Stowatear

Due to Carcinoma of the intestine, metastatic to the lwey.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION (?)

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr John H. Heaman M. D. or other

Address 221 1/2 Camden Ave Salisbury Date signed 9-6-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 7 1940
BUREAU V. S.

Dr. Mann

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09957

Reg. Dist. No. 333

**1. PLACE OF DEATH:**
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death 28 yrs
Hospital, institution, or street address where death occurred 614 Brown
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 614 Brown
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Robert S. Windsor

**3.(b) Social Security Number** 214-10-8352

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife Dotty B. Windsor
6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) April 18. 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 5 | 0 | hrs. min. |

9. Birthplace Salestown Md.
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name Zachaia Windsor
13. Birthplace Salestown Md.
MOTHER 14. Maiden name Lavenia Calloway
15. Birthplace Dorchester Co. Md.
16. Informant Mrs. Dotty B. Windsor
Address 614 Brown St. Salisbury Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 20-1940 (month) (day) (year)
Cemetery or crematory Odd Fellows Cem.
Location Laurel Delaware
18. Funeral director Holloway & Walter R. Holloway
Address Salisbury Md.
19. 9/20/1940 (Date rec'd by registrar) Harriet E. Johnson Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Sept. 18. 1940 at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940, to Sept 18 1940
and that I last saw him alive on Sept. 15 1940

| Immediate cause of death | DURATION |
|---|---|
| Carcinoma of Bladder | 14 years |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Injured at work?

23. SIGNATURE Hunter R Mann M. D. or other
Address Salisbury Md Date signed 9/20/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 7 1940
BUREAU V. S.